MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address RHD Memorial Medical Center P.O. Box 809053 Dallas, TX 75380	MDR Tracking No.: M4-03-6610-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Co. Box 54	Date of Injury: Employer's Name: Montague County Insurance Carrier's No.: 99C0000319923

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/22/02	08/26/02	Inpatient Hospitalization	$26,520.56	$18,356.03

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position summary; however, the Requestor's rationale as listed on the Table of Disputed Services states, "Carrier claims charges fall below stop loss so they paid per diem. TWCC Rule 134.401©(6) – indicates that charges must exceed $40,000 to be eligible for stop loss and if they do, the bill should be reimbursed at 75%. It defines audited charges as charges that remain after bill review has been performed and indicates the charges that may be deducted are personal items and items not related to injury. Carrier's EOB states 'audited charges fall below stop loss.' No onsite audit was performed. No indication is made that items not related to the injury were subtracted. The only change that may be deducted is the personal items charge of $25.55."

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "…The principal diagnosis code listed on the billing form was ICD-9 code 824.8. Commission Rule 134.401, *Acute Care Inpatient Hospital Fee Guideline* (c) states in part that payment for trauma ICD-9 codes 800.0-959.50 when listed as the primary diagnosis will be reimbursed as a fair and reasonable amount… In conclusion, Texas Mutual has determined that $4936.00 is fair and reasonable payment for a 4-day surgical trauma inpatient hospital stay. RHD Memorial Medical Center failed to meet its burden of proof to establish Texas Mutual still owes RHD Memorial Medical Center after Texas Mutual's payment and that the fees paid to date fall below the statutory standard…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). In this particular admission, the principle diagnosis code was 824.8 related to trauma care for a fractured ankle. Pursuant to Rule 134.401(c)(5), the reimbursement for the entire admission shall be paid at a fair and reasonable rate as neither the per diem method nor the stop loss method apply to this case.

Determining the "fair and reasonable" reimbursement can be difficult. In this case, it appears that neither the requestor nor the respondent have persuasively shown that their position represents the appropriate amount. Therefore, an alternate approach is needed to determine the reimbursement amount.

Based on the data contained in the Commission's medical billing database for dates of service in 2002, trauma admissions were reimbursed, on average, at 55.5% of the total charges (total payments divided by total charges). Applying this same formula to this specific case appears to be a sound method to determine the appropriate fair and reasonable reimbursement.

Accordingly, the health care provider is entitled to a total reimbursement amount of $23,292.03. This was calculated by multiplying the total changes of $41,967.63 by 55.5%.

Since the carrier has previously paid $4,936.00, the health care provider is entitled to additional reimbursement in the amount of $18,356.03.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $18,356.03. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Allen McDonald	04/04/05
Authorized Signature	Typed Name	Date of Order

Decision by:

	Marguerite Foster	04/04/05
Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____